LOS ANGELES COUNTY COMMISSION ON HIV

3530 Wilshire Boulevard, Suite 1140 • Los Angeles, CA 90010 • TEL (213) 738-2816 • FAX (213) 637-4748
www.hivcommission-la.info

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COMMISSION ON HIV
MEETING MINUTES
March 10, 2011

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	PUBLIC	OAPP/HIV EPI STAFF
Carla Bailey, *Co-Chair*	Tonya Washington-Hendricks	Ernesto Alda	Kyle Baker
Michael Johnson, *Co-Chair*	Jocelyn Woodard/Robert Sotomayor	H. Avilez	Michael Green
Al Ballesteros	Fariba Younai	Miguel Ayala	Carlos Vega-Matos
Robert Butler		Patricia Bermudez	Amy Wohl
Fredy Ceja		Robert Boller	Juhua Wu
James Chud	**MEMBERS ABSENT**	Susan Forrest	
Whitney Engeran-Cordova	Sergio Aviña	Aaron Fox	
David Giugni	Anthony Braswell	Joseph Green	**COMMISSION STAFF/CONSULTANTS**
Jeffrey Goodman	Carrie Broadus	Shawn Griffin	
Thelma James	Nettie DeAugustine	Miki Jackson	Dawn McClendon
Lee Kochems	Douglas Frye	David Kelly	Jane Nachazel
Bradley Land	Anna Long *(on leave)*	Ayanna Kiburi *(by phone)*	Glenda Pinney
Ted Liso	Jenny O'Malley	Howard Maldonado	James Stewart
Abad Lopez	Stephen Simon	Philip Mojica	Craig Vincent-Jones
Quentin O'Brien	Kathy Watt	Joanne Oliver	Nicole Werner
Dean Page/Terry Goddard		Jose Pareda	
Angélica Palmeros		Jill Somers *(by phone)*	
Mario Pérez		Nick Truong	
Karen Peterson		Sharon White	
Juan Rivera		Jason Wise	

1. **CALL TO ORDER**: Mr. Johnson called the meeting to order at 9:25 am.
   A. **Roll Call** (**Present)**: Bailey, Butler, Ceja, Engeran-Cordova, Giugni, James, Johnson, Land, Liso, Lopez, O'Brien, Page/Goddard, Palmeros, Pérez, Peterson, Rivera, Washington-Hendricks, Woodard

2. **APPROVAL OF AGENDA**:
   MOTION 1: Approve Agenda Order ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**:
   MOTION 2: Approve minutes from the 2/10/2011 Commission on HIV meeting ***(Postponed)***.

4. **CONSENT CALENDAR**:
   MOTION 3: Approve Consent Calendar with Motions 4 and 5 pulled for discussion ***(Passed by Consensus)***.

5. **PARLIAMENTARY TRAINING**: There was no report.

6. **PUBLIC COMMENT, NON-AGENDIZED**: There were no comments.

7. **COMMISSION COMMENT, NON-AGENDIZED**: There were no comments.

8. **PUBLIC/COMMISSION COMMENT FOLLOW-UP**: There were no comments.

9. **CO-CHAIRS' REPORT**: There was no report.

10. **EXECUTIVE DIRECTOR'S REPORT**:
    - Mr. Vincent-Jones noted the acronym list in the packet. An accompanying glossary is also in the works. Both will be posted on the Commission's website.
    - A conflicts of interest list based on OAPP contracts was in the packet. They are stated for priorities and allocations votes.
    - ➲ Contact the Commission offices for corrections or additions to either list.

11. **HEALTH CARE REFORM (HCR)/1115 WAIVER HEARING**:
    - Ms. Peterson indicated that two clients this week removed from fee-for-service Medi-Cal and enrolled in LA Care without notice. She learned with effort how to reverse decisions, but urged OAPP work with LA Care on the issue and HCR TF attention.
    - Mr. O'Brien understood no one should be moved prior to their first birthday after 6/1/2011. It would be useful to know if the noted moves were premature or pertained to certain codes. He urged client education on plan choice and talking to their current providers. Mr. Ballesteros suggested OAPP advise providers to inform clients they are available to help.
    - Ms. Woodard received a letter from Medi-Cal last Friday week informing her she would be transferred to an HMO of her choice or one chosen for her by her birthday. She is investigating options. She noted Medi-Cal often sends materials not related to her, so she does not always open them promptly. She is concerned many people may not open notices.
    - Mr. Butler felt it important to track these migrations now that they have begun to avoid losing track of clients.
    - Mr. Land said he understood LA Care has no HIV specialty care and recommended Ryan White (RW) assume it to ensure standards of care. Mr. Johnson said County clinics will become providers for LA Care once negotiations are complete. That will include Department of Health Services (DHS) clinics for HIV services. DHS is briefing the Board weekly on negotiations.
    - Mr. Johnson asked if OAPP had an inventory of contracted MO providers who are also managed Medi-Cal plan providers.
    - Dr. Green replied OAPP knows which MO providers are members of one Medi-Cal plan and are seeking data on others. Efforts continue to build Healthy Way LA and LA Care relationships, but they lack time and/or specifics to address OAPP questions. OAPP plans a meeting with all contracted MO providers and hopes the plans can come to answer questions.
    - Mr. Johnson recommended the Consumer Caucus address informing consumers about which MO providers are members of which plans. Mr. Vincent-Jones urged OAPP coordination to avoid duplicative work. Mr. O'Brien felt multiple information sources would confuse consumers and distract from provider communication with them. He added it is important to avoid any hint of marketing, but to communicate, "Pay attention. You have choice in determining the provider you want."
    - Mr. Engeran-Cordova noted his agency, AIDS Healthcare Foundation (AHF), has a managed care plan. He has often said HCR presages new constructs, e.g., employers now mainly offer HMO plans. Providers need to join managed care plan networks to maintain HIV expertise. Many studies show they can reduce hospitalizations and improve health outcomes.
    - Mr. Goodman noted he was on Medi-Cal until last year. He felt Medi-Cal managed care plans were better than straight Medi-Cal. He is working with Mr. Simon, City of Los Angeles, on consumer colloquia on managed care. Mr. O'Brien added Medi-Cal fee-for-service is the worst care as low reimbursement impairs provider ability to offer services.
    - Mr. Johnson agreed more services will be available via managed care. The issue is to help clients navigate managed care plans. Not all providers are ready to do that, so consumers must be enabled. He had been a health care attorney who represented physician networks against HMOs, but was unable to help himself when coming out of recovery.
    - ➲ Mr. Ballesteros will forward the Medi-Cal letter to individuals from its website to Mr. Vincent-Jones for distribution.
    - ➲ Consumer Caucus Co-Chairs will agendize discussion of how best to communicate with consumers.

13. **TASK FORCE REPORTS**:
    A. **Health Care Reform (HCR) Task Force**: The TF will meet 3/15/2011, 2:00 to 4:00 pm, at the Commission offices.

B. **Comprehensive Care Planning (CCP) Task Force**:
- Mr. Vincent-Jones noted there was no February meeting due to an IT glitch. There may be an interim meeting, but the next scheduled TF meeting is 3/22/2011, 9:30 to 11:30 am, at the Commission offices.
- Mr. Goodman said the TF has formed groups on outline section due to Ms. Pinney for compilation by 3/11/2011.

C. **Commission/PPC Integration Task Force**: Mr. Butler reported the PPC will address the overall system at its 4/7/2011 meeting including Testing and Linkage to Care Plus (TLC+) provisions for both the care and prevention plans.

D. **Community Task Forces**: There were no reports.

14. STATE OFFICE OF AIDS (OA) REPORT:
- Ms. Kiburi, Chief, HIV Care Branch, called attention to the overview in the packet for the Stakeholders Meeting for CA: Planning for Health Care Reform hosted by OA on 5/2 to 5/3/2011 in San Francisco at the Federal Building.
- Meeting objectives are to develop a strategic approach to identify challenges, relevant information, partner with expertise in each area and steps to address each challenge. OA will develop a succinct report that outlines key challenges to HIV specific and non-HIV primary care health delivery systems including provider and work force issues.
- Regarding a prior question on consumer participation, Ms. Kiburi felt organizations invited should meet that need. Mr. Vincent-Jones noted invitees include planning groups for care/treatment and prevention, but not consumers specifically.
- OA continues work to complete all Local Health Jurisdiction (LHJ) contracts. OAPP does have an executed contract.
- Care Program advisors are completing annual fiscal and programmatic contract monitoring. They plan a visit in April.
- OA will release HCP and MAI allocations based on FY 2010 to LHJs on 3/11/2011. They will be revised later if needed.
- Work is ongoing on the Statewide Coordinated Statement of Need (SCSN). LHJs have been asked for their local plans.
- Ms. Somers, Chief, ADAP Branch, said the Legislature rejected the administration's FY 2011-2012 ADAP budget proposal which expanded share-of-cost for $16.8 million in General Fund savings. It identified new savings of $3 million in anticipated supplemental RW funds and $4 million in reduced transaction fees for the Pharmacy Benefits Manager contract recently awarded to Ramsel. The ADAP budget did not go to Conference Committee as both houses took the same actions.
- The Legislature also gave three directions to OA:
  1. Expand eligibility requirements and facilitate enrollment of ADAP clients into CARE/HIPP.
  2. Establish a premium payment program for the Managed Risk Medical Insurance Board's (MRMIB) Pre-Existing Condition Insurance Plan (PCIP).
  3. Coordinate movement of ADAP clients into low-income health insurance programs, i.e., essentially 1115 Waiver plans.
- Mr. Engeran-Cordova asked about OA plans for the remaining $9.8 million in requested savings assuming the newly identified savings do equal $7 million. Ms. Somers replied OA will be reviewing how to implement the three directions for savings assuming they remain in the budget, but Mr. Engeran-Cordova felt possible savings from them were soft.
- Mr. Land asked how the Commission can help OA close gaps. Ms. Somers said OA gets program implementation direction once the budget is done. Documents will be drafted for input via stakeholder meetings which can include consumers.
- Regarding a prior question on other potential cuts, Ms. Kiburi said OA is committed to adjusting the HIV Care Program (HCP) and MAI allocations each year toward the unadjusted allocation based on the formula consistent with the OA objective to allocate funding based on epidemic prevalence. Previous HCP adjustments such as hold harmless will be used.
- Ms. Kiburi addressed prior test kit questions. She said the CPG Comprehensive Care, Prevention and Surveillance Plan will address resource allocation including test kits, but unmet need in Los Angeles is more than all CDC test kit resources for California. The CDC provided $685,000 in supplemental prevention funds. OA designated $585,000 for test kit purchases. Each LHJ provided a request for additional kits and OAPP requested 4,400 kits plus controls that equaled $52,430.
- Mr. Engeran-Cordova asked about the OAPP test kit request of about 10%. Mr. Pérez said additional resources are often so late that OAPP has already shifted resources to providers. Once bought, kits must be used before they expire. He added the County has 38% of California disease burden and questioned allocating 85% of funds to kits despite other prevention needs.
- ➲ Contact Dr. Michelle Roland, Chief, with concerns or suggestions regarding the Stakeholders Meeting invitation list. Ms. Kiburi will forward Mr. Vincent-Jones' concern about lack of specific consumer representation.
- ➲ Ms. Somers will ask Dr. Roland if OA has independent authority to enact a share-of-cost program to close the savings gap.
- ➲ Ms. Somers will ensure consumers are included on the stakeholder list for discussion of budget program draft documents.
- ➲ Ms. Somers will ask Dr. Roland if any of the original $16.8 million in planned savings were due to people lost to care.
- ➲ Ms. Kiburi will check on when OA guidelines for the electronic reporting bill, AB 2541, will be ready.
- ➲ Ms. Kiburi will find out from Brian Lew, Chief, HIV Prevention Branch, if all test kit funds were spent.

- Staff will request that OA provide a written report for Commission meetings.

A. **California Planning Group (CPG)**:

- Mr. Goodman presented on the new CPG. He had provided the same presentation to the PPC the prior week.
- The CPG was founded in April 2011. It replaces the California HIV/AIDS Planning Group (CHPG).
- CDC requires Health Departments and Community Planning (CP) groups to develop Prevention Plans collaboratively. CPs must be open, candid and participatory involving those at greatest risk and PLWHA. CPs are encouraged to seek input from marginalized populations and difficult to recruit/retain scientific and agency representation.
- Mr. Goodman noted it is not feasible to include all pertinent groups on the CPG due to effective size limitations, but participation can be supported through public meetings, focus groups, ad hoc panels and the internet.
- The CDC is poised to replace the current 2003 CP guidance with a new one anticipated in April 2011.
- CDC key tenets are Parity, Inclusiveness and Representation (PIR). Representation is defined as an official member with expertise in HIV prevention needs of represented populations and ability to weigh overall jurisdiction needs. Inclusion is defined as meaningful involvement of members in the overall process with an active voice in decision making to reflect multiple perspectives and needs. Parity is defined as member ability to equally participate and carry out tasks and duties with opportunities for orientation and skills building to ensure an equal voice in voting and decision making.
- HRSA mandates duties per legislation for Part A Planning Councils (PCs) in particular Priority- and Allocation-Setting. Membership must reflect the epidemic, e.g., 33% must be unaffiliated consumers and reflect demographics.
- HRSA Part B Consortia also have mandated duties. California disbanded its Part B Consortia, so mandates are moot.
- HRSA also has Part B (PCs). The California Part B grantee is OA. The CPG is an integrated body for surveillance, prevention and care and, thus, the Part B PC. Unlike Part A PCs or Part B Consortia, Part B PCs have no mandated authority to dictate priorities and allocations. “Community involvement” is mandated. The Part B grantee must consider reflectiveness of community input which is not limited to the CP, but the manner is not prescribed.
- The previous CHPG had over 40 members and rotated quarterly meetings around the State. Its stated mission was broad: Provide community perspectives, advice and recommendations in planning, development and resource allocation for a comprehensive, client-centered continuum of prevention, care, treatment and support services and serve as PLWHA advocates. While admirable, it was not feasible for a large body meeting quarterly.
- CHPG members held a self-review from June 2008 through September 2009. It was agreed the “community wants and needs” CHPG redefinition, restructuring, and clear roles/responsibilities to focus on work products and a shared vision.
- The CPG first met in April 2010 and has since met in October, December and February 2011. Membership was set at 15 to 21, now 15, with a focus on planning qualifications first as well as traditional inclusionary/reflectiveness criteria. Co-Chairs are: Governmental, Ms. Kiburi and Mr. Lew; Community, Valerie Rose, Oakland/San Francisco Bay, and Mr. Goodman. Co-Chairs will meet soon with CDC and HRSA Project Officers for input on CPG work.
- Primary responsibilities identified were development of an integrated Prevention and Care Plan, monitoring and evaluation of OA progress and effectiveness in addressing goals and objectives, mid-course updates as needed and providing periodic advice on emerging issues generated by OA or the community. The CPG reports to OA. It makes recommendations, not decisions, and is one component of community involvement including coordination.
- The CPG is work group driven with groups established and disbanded as needed for the Plan due January 2012.
- Groups that have completed or nearly completed work to date are: Architecture, produce integrated Surveillance, Prevention and Care Plan outline, Plan adopted and group disbanded; Governance, develop streamlined set of By-Laws, nearing completion; Membership, define membership requirements, terms and so on, nearing completion.
- Ongoing groups are: Community Assessment, collect and assess plans throughout the State; Data Analysis Work Group (DAWG), consult with plan groups, evaluate data presentation and use; Stakeholder Engagement, broaden stakeholder base and channel information; Website, maintain page on OA website with links on CPG work; Monitoring, Evaluation, Goals and Objectives (MEGO), including consistency with the National HIV/AIDS Strategy (NHAS); Priority Setting; and Resource Allocation, includes OA approval to review State formulas to develop a community recommendation.
- One challenge was a six month gap in face-to-face meetings due to State travel restrictions. Travel is not State paid, but was deemed inappropriate when others could not. E-meetings were good for presentations, but not for discussion.
- Perspectives are still developing as “state planners,” not local advocates, and on state and local plan differences.
- The Advisory Network (AN) was designed to capture a broader base of community members as another aspect of community involvement. A key AN challenge is that just 267 people statewide have signed up. Other challenges are to establish ways to identify member reflectiveness and to incorporate feedback into CPG agendas for consideration.
- The four levels of AN involvement are:

1. Instant email sign-up for notification of all OA announcements including from the Resource Identification, Dissemination and Linkage Task Force (RIDL) which provides information on all non-State funded resources.
2. Discussion board sign-up is verified, generally in 24 hours, to ensure legitimate addresses. The boards have not been very active, but discussions receive prompt responses from Dr. Roland.
3. Sign-up for future surveys, input and quick response input. CPG will begin posting documents for feedback soon.
4. Send OA recommendations and requests. They will be forwarded to all AN members and the CPG which may disagree with OA's response for further OA consideration.

- The CPG also seeks to formalize collaboration with stakeholder groups such as the California Conference of Local AIDS Directors (CCLAD), LHJs, OA contractors, the California Medical Association (CMA), the advocacy coalition Alliance, local planning groups and people at HIV risk, affected or infected. All are asked to check the full list and suggest additions.
- Mr. Goodman said the intended user of the Plan is OA as it will be held responsible for monitoring, evaluation and mid-course corrections. The Plan follows the trend toward leaner, more action-oriented plans.
- The audience includes those with whom OA contracts services and, secondarily, those impacted by State action. He noted the County Ordinance authorizes Commission allocation of Part B funds, but many other LHJs lack that authority.
- Goals of the new model are cost efficient community planning with an emphasis on community expertise, the ability to respond quickly and the broadest possible base of stakeholder engagement.
- Continuing concerns are whether funders are ready for innovation, ensuring the CPG stands up to public scrutiny on reflectiveness, improving AN participation and the flow of information and advise to CPG from non-AN sources.
- After the Plan is completed, work will continue on monitoring, evaluation and revision to meet changing needs; review of the allocation formula; and review of HCR and 1115 Waiver impact.
- The CPG will address public comments submitted in writing to Carol Crump at carol.crump@cdph.ca.gov.
- Mr. Land complimented the work, but was concerned about CPG unaffiliated consumer representation. Mr. Goodman noted the first CPG membership criteria tier is expertise in writing a comprehensive care and prevention plan with diversity second. One-third is HIV+ and four non-aligned. The CPG is only one aspect of community involvement.
- Mr. Ceja was on the previous CHPG. While discussion was lively, the CHPG was routinely asked to rubber-stamp a plan which was then shelved. He recommended asking legislators to give the CPG authority to direct OA to follow its recommendations. Mr. Goodman noted the CPG will actually develop this Plan with Ms. Crump the unifying writer.
- Mr. Ceja asked about the previous CHPG's advisory groups such as those for Latino/as and Transgenders. Mr. Goodman replied the CPG hopes many of those groups will reform electronically, e.g., via the AN.
- Mr. Butler felt if the sole focus is to get the work done something is left out of the work. Minorities especially are less likely to be on the internet. He understands economic restrictions, but urged something easier like a phone number.
- Mr. Goodman noted most State Part B funds go to LHJs and not to direct services, so the CPG does not prioritize service categories as LHJs do. The CPG might prioritize directions to LHJs or review allocation models, but that is very different.
- Ms. Forrest, a previous CHPG member, felt the OA attitude toward the end was condescending. She was concerned the AN will languish and there will be no accountability. Ms. Kiburi replied the commitment is to ensure broad review and input throughout Plan development. OA will use the Plan and the CPG is charged with monitoring that.

15. OFFICE OF AIDS PROGRAMS AND POLICY (OAPP) REPORT:

- Mr. Pérez noted the 3/7/2011 OAPP Monthly Update to the Commission from Dr. Green, Chief, Planning, in the packet.
- Due to the Federal Continuing Resolution, OAPP received a partial FY 2011 (YR 21) Part A and MAI notice of grant award of $14,125,730 on 2/26/2011. It reflects about 50% of the FY 2010 Part A Formula and MAI award. It is not known at this point whether the FY 2011 Formula and MAI award will be adjusted or what the Supplemental award will be.
- Dr. Jonathan Fielding, Director, Department of Public Health, announced 2/24/2011 the organizational alignment of OAPP, HEP and STD Program. The decision addresses local realities such as reducing duplication and is consistent with CDC intent to promote program coordination and service integration. The Commission-OAPP MOU is on hold pending integration.
- Integration will take at least a year starting with a robust assessment. Mr. Pérez has identified staff from each program for an Integration Advisory Team to review such elements as administration, fiscal, programmatic and data use across systems.
- Ms. Jackson was concerned about a potential loss of HIV focus and increased administrative costs. She urged transparency.
- Mr. Pérez said he and Dr. Fielding stress that integration will not dilute emphasis on the local HIV epidemic. In fact, it should help, e.g., in addressing STD co-occurrence among PWH as well as the many people at risk for HIV who present with STDs.
- Mr. Engeran-Cordova asked about roles of the Commission, the Commission/PPC Integration Task Force and the PPC in this integration. He noted community planning has been episodic in the STD Program, but hoped for robust discussion.

- Mr. Pérez felt the time is ripe for an integrated approach to community planning that not only considers HIV and STDs, but the social constructs, economic issues, mental health, substance abuse and other morbidities that drive these epidemics along a continuum of prevention, care and treatment services. He did not have community planning process details yet.
- He said planning should be congruent with a new way of approaching activities on the ground, e.g., as we develop Testing and Linkage to Care Plus (TLC+) models. Various issues of an Individual client are often already approached in a holistic manner as it is more effective, so this can be an opportunity to improve the comprehensiveness of our local planning.
- Mr. Vincent-Jones asked about the Data Management RFP and Medical Care Coordination (MCC) implementation. Mr. Pérez said the RFP is on hold to explore options for a more robust system with multiple morbidities and some surveillance.
- He added that program integration is not the only spur to review the Data Management RFP. HCR is influencing stakeholder conversations on the Medical Outpatient (MO) RFP. There will be more certainty in the weeks leading to the 6/1/2011 initiation of 1115 Waiver reforms for MO, Medical Specialty and MCC. All will need a Data Management system consistent with data collection expectations for those providers, so OAPP is seeking to time decisions to incoming information.
- Mr. Johnson felt the MOU and MCC could be implemented and amended later if needed. He was concerned long delays undermine consumer confidence and suggested the Commission and OAPP work to implement both as swiftly as possible.
- Ms. Washington-Hendricks suggested help with the current data system while waiting for the new. Mr. Pérez noted a now inactive Casewatch User Group to identify end user data system needs and address process improvement and trouble-shooting. It provided OAPP a needs assessment for a diverse cross-section of providers. OAPP considered State and Federal reporting requirements as well as ease of data collection, input and access in helping define attributes of a new system.
- Mr. Pérez reported work on the Benefits Specialty RFP is nearly complete. Services have been supported with 12 providers countywide since 1/1/2011. Contracts were amended to ensure services and training has begun for all Benefits Specialists.
- On Oral Health, Mr. Pérez noted Mr. Vega-Matos' earlier PowerPoint in the packet on the state of the service including a significant increase in numbers of people served and visits provided. OAPP has requested HRSA Technical Assistance to help assess unmet need and develop capacity. Some providers have said they have opportunities to expand services which Mr. Vega-Matos will assess. OAPP wants to ensure RW resources increase service rather than supplant existing services.
- Dr. Green reported Karen Ingvoldstad, Part A Project Officer, plans site visits in April with several California grantees including Los Angeles. Tentatively, she plans to be here the week of 4/11/2011 and attend the 4/14/2011 Commission.

➲ Mr. Pérez said OAPP will host a meeting, to be announced within four weeks, of all Casewatch users on current challenges.

16. HIV EPIDEMIOLOGY PROGRAM (HEP) REPORT:

A. **Retention in Care**:

- Dr. Wohl, Chief Epidemiologist, presented results of a study on the influence of social support, stress, disclosure and stigma on retention in care for Latino and African-American (A-A) women and MSM. Secondarily, the study tested for racial/ethnic and gender/sexual orientation differences within the populations which have high care consistency issues.
- Strong social support is associated with high quality, consistent care for asthma, diabetes and heart disease, but there is little research on HIV. The association between support, stress, disclosure, stigma and care is notable among Latino and A-A populations due to high HIV and MSM stigma in those communities which can impact care-seeking behavior.
- A cross-sectional study design was used to enroll 400 participants with 100 each among Latino MSM, Latinas, A-A MSM and A-A women. The balanced distribution provides adequate power to review differences between and within groups.
- Eligibility criteria were: confirmed HIV+ status, self-identity as Latino/a or A-A, 18 or older, ability to complete survey in English or Spanish, patient at one of five participating clinics and reported history of sex with men for men.
- Participating clinics were: Altamed Daniel V Lara HIV Clinic; Harbor-UCLA HIV Clinic; Oasis Clinic at MLK-MACC; LAC-USC Medical Center Rand Schrader Clinic and LAC-USC Medical Center Maternal, Child and Adolescent Clinic.
- 400 people were selected from 443 recruited at clinics with flyers and provider referrals. One A-A MSM was found ineligible post-enrollment and excluded for 399 enrolled from 11/2007 to 8/2008. Characteristics were similar to other representative studies of County PWHA: 62%, 30 to 49; 75% of Latinos were foreign-born; 35%, less than high school education; 79%, annual income less than $12,000; 77%, unemployed; 19%, IDU history; 38%, no health insurance.
- Retention in HIV care was defined as two or more primary HIV care visits in the six months before the study interview which is consistent with the HCSUS retention in care definition and USDHHS guidelines during the study period.
- Bivariate analyses used t-tests for all participants to compare retained versus not retained in care with general versus HIV-specific support and overall versus HIV-specific stress. There was no retention difference for those receiving general support, but it rose for those who received HIV-specific support such as appointment reminders. There was no retention difference from overall stress except for A-A MSM. Retention did improve with higher HIV-specific stress.

- The total number of people in social networks was similar for those retained versus not retained in care, but retention increased with the number of those to whom HIV status was disclosed which became an important retention predictor.
- HIV-related stigma did not affect retention in care, but MSM-related stigma did reduce retention in care.
- Multivariate analyses used a multi-step screening process and a modified bootstrap approach to find the most important predictors for each subgroup.
- MSM-related stigma was the major Latino MSM predictor for reduced retention, but neither stigma, stress nor general support was predictive for other subgroups. The number of social network members to whom HIV status was disclosed was predictive of retention for Latinas and A-A women and was the major predictor for the overall study group.
- Among women who had disclosed their HIV status, the number to whom Latinas had disclosed was predictive of their retention. Higher CD4 counts were predictive of retention for A-A women, but that may result from being in care.
- Among the entire group of those who had disclosed their HIV status, women were more likely to be retained in care than MSM with overall higher numbers of people to whom status was disclosed associated with higher retention.
- Data is limited in that only HIV+ persons in care were included, the study used their perceived social support and stress, and support networks may differ among PWH not in care. In addition, some cell sizes are small which limits confidence in the data. Some findings also reflect temporal ambiguity, e.g., CD4 count and retention may influence one another.
- Main Finding 1: The number of network members to whom HIV status was disclosed was a significant predictor of retention for the overall sample, for all who had disclosed their status and for Latinas who had disclosed their status.
- This implies disclosure to social network members may facilitate access to care or allow a patient to pursue care without concealment. It suggests the importance of developing interventions for Latinas and other subgroups with counseling to help identify social network members to whom status can be disclosed safely.
- Main Finding 2: General stress was associated with retention in care for A-A MSM who had disclosed their status.
- This suggests A-A MSM may go to care visits in part for support and positive interaction from providers not felt in other parts of their lives. It is also possible "positive nagging" from their social network members may prompt care visits.
- Main Finding 3: Among all Latino MSM and among only Latino MSM who had disclosed their status, more MSM stigma was associated with poorer retention.
- This suggests HIV+ Latino MSM are so affected by MSM stigma they may forgo lifesaving care. Findings suggest the importance of developing Latino MSM interventions with social network members to reduce MSM stigma.
- Ms. Washington-Hendricks asked how providers were chosen. Dr. Wohl noted the County's epidemic is concentrated among Latino/as and A-A, so providers were targeted that served those populations.

17. **PREVENTION PLANNING COMMITTEE (PPC) REPORT**: This item was postponed.

18. CAUCUS REPORTS:

A. **Consumer Caucus**:

- Mr. Land noted the Mobilization List sign-up form was revised, per suggestions, to include a Spanish language section.
- ➲ Staff will distribute a flyer on the SPA 6 Roundtable at MLK-MACC shortly.

B. **Latino Caucus**: This item was postponed.

19. **STANDING COMMITTEE REPORTS**:

A. **Priorities & Planning (P&P) Committee**:

1. ***FY 2010 Financial Expenditures***: The report was in the packet.
2. ***SAM/Part B Re-Allocation***:
   - Mr. Land, Co-Chair, noted the 2/16/2011 OAPP Monthly Update to P&P from Dr. Green and the 3/8/2011 memorandum from P&P to the Commission with background on re-allocation recommendations in the packet.
   - Mr. Ballesteros, Co-Chair, noted savings per the spreadsheet. OAPP recommended shifting the funds to Residential Care (RC) for full expenditure. P&P concurred provided NCC expenditures for care and treatment are not reduced.
   - Mr. Vega-Matos previously provided a presentation on changes to RC. There are two primary service categories: Residential Care Facilities for the Chronically Ill (RCFCI) and Transitional Residential Care Facilities (TRCF).
   - RCFCI serves those who are homeless or have very unstable housing and need assistance with activities of daily living under State Code of Regulations Title XXII. OAPP did an extensive review in 2010 and contracted services.
   - TRCF, previously Adult Residential Facilities (ARF), also used to be provided under Title XXII. The Commission and OAPP worked to remove it to better match the population's need. One contract was awarded.

- Skilled Nursing and Hospice has traditionally been under RC. Only one consumer accessed that service last year and the contract sunset in 12/2010. The Commission and OAPP have a work group to review the service.
- Other services previously were provided under RC, but were sunset as duplicative with HOPWA services. RC does not include Residential Substance Abuse or Residential Transitional Substance Abuse services which are separate.
- Mr. Engeran-Cordova noted Expenditure Reports seem to show Early Intervention Services (EIS) seems close to the underspending while MO was overspent. Mr. Vincent-Jones said EIS underspending is similar, but not related. MO had unanticipated costs as did Home-Based Case Management addressed in the 12/2010 Part A re-allocation.
- If Part A/Part B (SAM Care) funds are used for RC then an equivalent amount in NCC funds is unencumbered. P&P directed NCC funds stay in care and treatment. SAM Care must be expended by fiscal year end on 6/30/2011.
- He added the directive is in the form of an expectation allowed by legislation and HRSA guidance.
- Mr. Engeran-Cordova asked if shortfalls could be identified sooner. Mr. Vincent-Jones said P&P receives monthly reports, but they lack substance until the last six months when contracts are modified and expenditures invoiced. P&P was aware of, and addressed, many of the under- and overspending issues with the Part A re-allocation, but was somewhat surprised by the additional Part B (SAM Care) issue first reported at the 2/1/2011 P&P meeting.
- Ms. White, SPA 6, said many Residential Substance Abuse facilities have closed, yet need remains. Mr. Vincent-Jones said RC was partly chosen as it was NCC funded, so the shift allows full Part A/Part B (SAM Care) expenditure.
- Mr. Pérez felt OAPP has made significant progress in informing the Commission about Part A, Part B (SAM Care), MAI and NCC expenditures. Underspending can result from various causes and is more difficult to manage due to administrative changes which restrict OAPP to allocating just $1 for each $1 in funding.
- OAPP is responsible for addressing the entire HIV/AIDS epidemic including some 3,000 annual infections and 13,500 undiagnosed. The $17.3 million allocated by the Board as part of the Maintenance of Effort required by HRSA is also for the entire system. He felt the directive makes the most nimble response to challenges harder.
- Mr. Ballesteros appreciated the challenge. The directive just retains the NCC level and can be reviewed if needed.
- Ms. Jackson questioned the definition of "entire system" in lieu of program integration. She also asserted some $7 million in NCC has shifted from care and treatment support to less concrete purposes over the last three years.

MOTION 4: Re-allocate $1,297,182 in underspent Part B/SAM Care funds to Residential Care provided that the total commitment of NCC dollars to care and treatment services, as reflected in the 2/22/2011 financial expenditures report, remains, at a minimum, the same through FY 2011 ***(Passed: 14 Ayes; 2 Opposed; 0 Abstentions)***.

3. ***FY 2011 MAI Re-Allocation***:
   - Mr. Land reported OAPP recommended P&P add Transitional Case Management to existing MAI allocations for FY 2011 to allow for absorption of the FY 2010 MAI overlap/carryover pending approval from HRSA.
   - P&P recommended maintaining current designated MAI service categories and allocating overlap/carryover funds to Oral Health Care in lieu of the OAPP service evaluation and ongoing expressed need from multiple sources.

   MOTION 5: Allocate FY 2010 MAI overlap/carry-over funds to current designated MAI service categories and to specifically invest those funds to build network capacity for Oral Health Care services, which can include additional staffing, lab fees, equipment and facilities (with HRSA's consent), or other needs to continue improving oral health outcomes ***(Passed by Consensus)***.

B. **Standards of Care (SOC) Committee**: This item was postponed.

C. **Operations Committee**:
1. ***Membership Nominations***:
   MOTION 6: Approve the nominations of Ted Liso to the District 3 Consumer seat, Jim Chud to the District 3 Consumer Alternate seat, Alberto Orozco to the SPA 7 Consumer seat, David Kelly to the SPA 7 Consumer Alternate seat, Joe Green to the SPA 4 Consumer Alternate seat and Kathy Watt to the PPC representative seat and forward to the Board of Supervisors for appointment ***(Passed as part of the Consent Calendar)***.
2. ***Commission New Member Orientation***: The meetings will be 4/14/2011 and 5/12/2011, 2:00 to 4:00 pm, at St. Anne's.

D. **Joint Public Policy (JPP) Committee**:
1. ***Change in Meeting Day/Time***: The meeting has moved to the fourth Wednesday of the month from 2:00 to 5:00 pm.

20. PUBLIC HEALTH/HEALTH CARE AGENCY REPORTS: There were no reports.

21. **SPA/DISTRICT REPORTS**: There were no reports.

22. **COMMISSION COMMENT**: There were no comments.

23. **ANNOUNCEMENTS**: There were no announcements.

24. **ADJOURNMENT**: Mr. Johnson adjourned the meeting at 2:15 pm.

A. Roll Call (**Present)**: Bailey, Ballesteros, Butler, Engeran-Cordova, James, Johnson, Kochems, Land, Liso, Lopez, O'Brien, Palmeros, Pérez, Peterson, Rivera, Washington-Hendricks, Woodard

MOTION AND VOTING SUMMARY		
MOTION 1: Approve Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Approve minutes from the 2/10/2011 Commission on HIV meeting.	***Postponed***	**MOTION POSTPONED**
MOTION 3: Approve Consent Calendar with Motions 4 and 5 pulled for discussion.	***Passed by Consensus***	**MOTION PASSED**
MOTION 4: Re-allocate $1,297,182 in underspent Part B/SAM Care funds to Residential Care provided that the total commitment of NCC dollars to care and treatment services, as reflected in the 2/22/2011 financial expenditures report, remains, at a minimum, the same through FY 2011.	***Ayes:*** Bailey, Ballesteros, Butler, James, Johnson, Kochems, Land, Liso, Lopez, O'Brien, Palmeros, Peterson, Rivera, Woodard ***Opposed:*** Engeran-Cordova, Washington-Hendricks ***Abstentions:*** None	**MOTION PASSED** **Ayes**: 14 **Opposed**: 2 **Abstentions**: 0
MOTION 5: Allocate FY 2010 MAI overlap/carry-over funds to current designated MAI service categories and to specifically invest those funds to build network capacity for Oral Health Care services, which can include additional staffing, lab fees, equipment and facilities (with HRSA's consent), or other needs to continue improving oral health outcomes.	***Passed by Consensus***	**MOTION PASSED**
MOTION 6: Approve the nominations of Ted Liso to the District 3 Consumer seat, Jim Chud to the District 3 Consumer Alternate seat, Alberto Orozco to the SPA 7 Consumer seat, David Kelly to the SPA 7 Consumer Alternate seat, Joe Green to the SPA 4 Consumer Alternate seat and Kathy Watt to the PPC representative seat and forward to the Board of Supervisors for appointment.	***Passed as part of the Consent Calendar***	**MOTION WITHDRAWN**